STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445358	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEBRIDGE HEALTH CARE CENTER	115 WOODLAWN DRIVE JOHNSON CITY, TN 37604

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K 000	INITIAL COMMENTS POC ACCEPTED SEP 3 2013 42 CFR 483.70(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 1995 K7 SURVEY UNDER: 2000 EXISTING K8 SNF/NF Type of Structure: One story, Type V (111), 1995, protected, combustible wood frame construction. The facility has seven smoke compartments and a complete automatic (dry) sprinkler system. A Comparative Federal Monitoring Survey was conducted on 8/14/2013, following a State Agency Survey on 07/16/2013, in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, LakeBridge Healthcare Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).	K 000	Disclaimer for Plan of Correction Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Lakebridge Health Care Center of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Lakebridge Health Care Center files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility	K 054	K 054 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care; but in order to respond to this citation from the surveyors, the facility is taking the following additional actions:	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Myda Bays — TITLE: Administrator — (X6) DATE: 8/29/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 054	Continued From page 1 failed to provide documentation of smoke sensitivity testing of the facility smoke detectors on the fire alarm system. The deficient practice affected seven of seven smoke compartments, staff and all residents. The facility has the capacity for 109 beds with a census of 101 the day of survey. Findings include: A review of the facility fire alarm system testing records on 8/14/2013 at 4:05 p.m. revealed the facility was unable to provide documentation of biannual smoke detector sensitivity testing since the last test performed on 7/1/2011. Two previous smoke sensitivity test reports dated 5/26/09 and 04/05/07 showed test frequencies over two years and contained data for smoke detectors that had failed the smoke sensitivity test. The facility failed to provide documentation of failures or nuisance alarms with a history of two complete bi-annual test cycles without failures in order to extend the duration in between tests. The most recent smoke sensitivity test was overdue by 45 days. Interview with the Maintenance Supervisor on 8/14/2013 at 4:05 p.m.,. indicated the facility was not aware of the requirement for biannual sensitivity testing. The census of 101 was verified by the Administrator on 8/14/2013. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 8/14/2013. Actual NFPA Standard: NFPA 72, 7-3.2.1. Smoke detector sensitivity shall be checked	K 054	Corrective Actions for Targeted Residents The Smoke Detector Sensitivity Test was completed on 8/29/13 and biannual sensitivity testing was scheduled by the Maintenance Director on 8/14/13. Identification of Other Areas with Potential to be Affected The Maintenance Director reviewed with the Fire Alarm Company on 8/14/13 that the Smoke Detector Sensitivity Tests must be scheduled biannually and proper documentation provided. Systematic Changes Measures to assure compliance include adding Life Safety Check Log, to include Biannual Smoke Detector Sensitivity Tests, to the already existing Life Safety Audit. This audit will be completed and documentation put in place on a monthly basis by the Maintenance Director. Monitoring Results of these audits will be reported monthly to the Performance Improvement Committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing,	

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K 054	Continued From page 2 within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked); the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.	K 054	Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director.	9/3/13
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 066 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents Metal containers were purchased on 8/28/13 by the Maintenance Director for the Staff Smoking Area near Zone 4 in order for ashtrays to be emptied and to permit smoking materials to be completely extinguished prior to disposal with other combustible trash.	

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K 066	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide metal containers with self-closing devices into which ashtrays can be emptied. The deficient practice affected one of two designated smoking areas and one of seven smoke compartments, four staff and no residents. The facility has the capacity for 109 beds with a census of 101 the day of survey. Findings include: Observation on 8/14/2013 at 2:00 p.m. revealed the designated outdoor Staff smoking area near Zone 4 was not equipped with a metal container with a self-closing cover into which ashtrays could be emptied and to permit smoking materials to be completely extinguished prior to disposal with other combustible trash. Interview on 8/14/2013 at 2 p.m. with the facility Maintenance Supervisor revealed the facility was not aware of the requirement to provide a metal container with self-closing cover in smoking areas. The census of 101 was verified by the Administrator on 8/14/2013. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 8/14/2013. Actual NFPA Standard: NFPA 101 19.7.4 (3), (4). Ashtrays of noncombustible material and safe	K 066	Identification of Other Areas with Potential to be Affected Smoking areas were inspected on 8/14/13 by the Maintenance Director to ensure that smoking materials can be extinguished prior to disposal with other combustible trash and were found to be compliant. Systematic Changes Measures to assure compliance include monthly Performance Improvement inspections, with documented results by the Housekeeping Director and the Maintenance Director to ensure that these containers are in place and used properly. Monitoring Documented results of these inspections will be reported monthly to the Performance Improvement Committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's	

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K 066	Continued From page 4 design are provided in all areas where smoking is permitted. Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted.	K 066	recommendations will be followed up by the Administrator and the Maintenance Director.	9/3/13
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review, observation, and interview, the facility failed to provide documentation of monthly 30 minute load testing for the emergency generator, failed to test the generator at 30% of name plate rating per month, and failed to perform a manual transfer of the generator power within 10 seconds for the Emergency Power Supply System (EPSS). The deficient practice affected seven of seven smoke compartments, staff and all residents. The facility has the capacity for 109 beds with a census of 101 the day of survey. Findings include: 1. During a review of the facility's emergency generator reports for the 12 months preceding the survey on 8/14/2013 at 3:45 p.m. the facility	K 144	K 144 Lakebridge Health Care Center believes its current practices were in compliance with the applicable standard of care, but in order to respond to this citation from the surveyors, the facility is taking the following additional actions: Corrective Actions for Targeted Residents The Maintenance Director has updated the monthly load test on 8/16/13 to show 30 minutes of run time under load. The Maintenance Director reviewed on 8/19/13 with the facility's contracted generator service to the name plate calculations for proper documentation. They also ensured that the generator was transferring correctly in the allotted 10 seconds. Identification of Other Areas with Potential to be Affected The Maintenance Director has reviewed generator documentation and operation of the generator with the contracted	

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K 144	Continued From page 5 was unable to provide documented 30 minute monthly load tests of the facility's emergency generator. The monthly generator test documentation showed 15 minute load test with a 15 minute cool down time. Interview with the Maintenance Supervisor on 8/14/2013 at 3:45 p.m. revealed the facility was not aware of the requirement for a consecutive 30 minute monthly load test. 2. During record review on 8/14/2013 at 3:50 p.m. of the facility's diesel generator inspection logs for the calendar year prior to the survey, the facility was not able to provide documented monthly load tests for 30% of the generator name plate rating. The generator monthly load test documentation stated the generator was run under 100% name plate rating every month. The generator was programmed to run automatically on a weekly basis, not under 100% of the name pate rating for the approximately 200 KW diesel generators. Interview with the Maintenance Supervisor on 8/14/2013 at 3:50 p.m. revealed the facility was not aware of the requirement to run the generator at 30% load monthly and to document correctly the actual load test results. The facility had a current annual load bank test for the diesel generator. 3. During testing of the diesel generator by the Maintenance Supervisor on 8/14/2013 at 4:30 p.m. the generator was turned on by switching off an electrical circuit on a panel in the transfer switch room. The generator did not transfer power over to the generator within the allotted 10 seconds or over one minute.	K 144	generator service on 8/19/13 and determined that no other items were affected and it compiles with NFPA Standards. Systematic Changes Measures to assure compliance include monthly Performance Improvement audits by the Administrator and Maintenance Director to ensure the NFPA Standards are met and that the generator is transferring emergency power in the allotted time. The Maintenance Director will consult with the contracted generator service during their semiannual inspection on proper load testing, operation of transfer switch and monthly load test documentation. Monitoring Results of these audits will be reported monthly to the Performance Improvement Committee for review and recommendations. The Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Consultant Pharmacist, MDS and Assessment Nurse, Housekeeping Supervisor, Maintenance Director, and Social Services Director. The Committee's recommendations will be followed up by the Administrator and the Maintenance Director.	9/3/13

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K 144	Continued From page 6 Interview with the Maintenance Supervisor on 8/14/2013 at 4:30 p.m. revealed the facility was not aware of the requirement to perform a manual transfer of the emergency generator under 10 seconds. The census of 101 was verified by the Administrator on 8/14/2013. The finding was acknowledged by the Administrator and verified by the Maintenance Supervisor during the exit interview on 8/14/2013. Actual NFPA Standard: NFPA 99, 3-4.4.1.1 (a). The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within a 10-second interval. Actual NFPA Standard: NFPA 99, 3-4.4.1.1 (b) 2. The scheduled generator test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads. Actual NFPA Standard: NFPA 110, 6-3.4. A written record of the EPSS inspections, tests, exercising, operation, and repairs shall be maintained on the premises. Actual NFPA Standards: NFPA 110, 6.4.1* and 6.4.2*. Level 1 and level 2 Emergency Power Supply Sources (EPSS)s, including all appurtenant components, shall be inspected weekly and shall be exercised under load monthly for a minimum of 30 minutes. Actual NFPA Standard: NFPA 110, 6-4.2*. Generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:	K 144		

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K 144	Continued From page 7 a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer The date and time of day for required testing shall be decided by the owner, based on facility operations. Actual NFPA Standards: NFPA 110, 6-4.5. Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144		